LETTER OF AUTHORIZATION (LOA)

FOR THIRD-PARTY RECORD RETRIEVAL

TO: Acadian Ambulance Service

RE: Request for Medical Records for:

Patient Full Name: _____

Date of Birth: _____ Social Security Number (Last 4): _____

Date of Service(s): _____

1. DESIGNATION OF AUTHORIZED AGENT

I, _____ (Name of Attorney/Adjuster), acting on behalf of _____ (Name of Firm or Insurance Company), hereby authorize:

NAME OF RETRIEVAL ENTITY: _____

to act as our authorized agent for the sole purpose of requesting, receiving, and handling the medical and/or billing records for the patient named above.

2. SCOPE OF AUTHORITY

This authorization allows the designated agent to:

- Submit requests for Protected Health Information (PHI).
- Receive invoices and submit payments on our behalf.
- Receive the final records via secure electronic delivery or mail.

3. IDENTITY VERIFICATION

I certify that I am an authorized representative of the hiring entity. This request is submitted via a verified firm/agency email domain or on official company letterhead to satisfy identity verification requirements.

4. DURATION

This authorization shall remain in effect for **one (1) year** from the date of signature unless otherwise revoked in writing.

AUTHORIZING SIGNATURE

Signature: _____ **Date:** _____

Printed Name: _____ **Title:** _____

Firm/Company Name: _____

Direct Phone: _____ **Email:** _____